U. S. Department of Agriculture
Office of the Secretary

Advance for Release 6:30 a.m. EDT
Thursday, Dec. 8, 1977

MEDICAL CARE IN RURAL DEVELOPMENT

The National Press Club recently held a luncheon in honor of Eric Sevareid, the distinguished commentator who just retired from CBS News. Mr. Sevareid, a native of North Dakota, told the audience that it is possible to go home again--you just can't stay.

I have been in Washington with the Carter Administration since February, and I'm not yet prepared to test the hypothesis of either Mr. Sevareid or Thomas Wolfe.

I am convinced, however, that if either Mr. Sevareid or Mr. Wolfe had been from New Mexico their statements--one classic and the other making the rounds in Washington, in national publications and in North Dakota--would have been different.

It is a pleasure to have a legitimate and important excuse to return to New Mexico, and to exchange views on Directions in Rural Health Care. Here in New Mexico I was deeply involved in health care issues, primarily rural, and my interest and responsibility have only increased with my new position.

Tomorrow, I am going to my hometown of Lumberton to partiicpate in the dedication of a water system; the most recent attempt to provide potable water to the 250 residents. This innovative new solar-assisted system, the result of work by the Four Corners Regional Commission and others, uses algae to purify the local water which has successfully resisted all previous attempts.

Remarks by Assistant Secretary Alex P. Mercure before the Presbyterian Hospital Center Conference on "Directions in Rural Health Care," Albuquerque, New Mexico, December 8, 1977, at 9:15 a.m.

USDA 3523-77

If this new water purification system does work in the cold mountains of Northern New Mexico, the concept may be of value in other communities across the country. But even with good water, the residents of Lumberton and much of the rest of rural New Mexico will still have many of the problems common to the some 60,000,000 Americans who live in rural places.

A few years ago, our kids were visiting my parents who, like my wife's, live near where they grew up. Let me make a point before I continue with this story.

Both sets of parents live a comfortable and reasonably prosperous life in Northern New Mexico. And they use a resource and a technology available to many rural Americans: wood and simple and efficient wood burning stoves. This is totally by choice. The wood is nearby and it allows them to convert their labor into an asset, and burning wood is much less expensive than the prices most of us pay for electricity, natural gas, butane, oil or whatever.

Just like the special circumstances that surround rural health care needs, there are rural realities which have for too long been ignored by federal agencies, including the Farmers Home Administration which is one of my responsibilities. We must become more sensitive to all of the needs of rural Americans, applying some of the less complicated solutions such as use of an available and renewable natural resource like wood.

Anyway, back to the kids visiting my parents. One of the boys, Enrique, age 4, fell down a ditch bank and punctured his side with a tree limb. My mother rushed him to the nearest clinic, in Coyote 13 miles away, for treatment. When my wife and I arrived, Enrique was fine and the repair job looked excellent. The limb had not hit any vital organ.

We were back up north in a week or so and it was time to have the wound checked. I took him in myself, partly because I wanted to thank and compliment the doctor who had done the work. But, as you probably have already realized, it was not an M.D. who had done such a good job of providing basic medical care to my son. It was a physician's assistant.

All of us here today can cite the facts--and we can do this to our advantage and benefit--that make health care a major issue as we try to develop a national rural policy.

* Infant and maternity mortality rates are higher in nonmetropolitan areas.
* Heavily populated areas attract more physicians than do rural areas (which are particularly lacking in specialists).
* Emergency medical care is severely lacking in rural places.
* Income in rural areas is less than in more populated areas, and the relationship to medical care is obvious.
* Even with the old RMP's and Hill-Burton, rural health care planning is less than adequate.
* Those who are very young or very old are particular victims of our rural health care systems.
* Chronic disease is often more prevalent among rural Americans.

The phenomenon of the movement of Americans from urban centers to rural areas beyond suburbia demonstrates not only the urgent need for a comprehensive and thoughtful national rural policy, but also is a graphic reminder of the relationship between cities and the countryside and what has happened since people last changed their living pattern.

Since early in this decade twice as many people have been moving to rural areas as to urban places, for a variety of reasons; personal, location of industry and others. This is unprecedented in the history of the world. There are rural communities still declining in population and development, those which are growing at a manageable rate and still others such as energy-impacted places which offer dramatic and immediate problems.

This migration from urban areas is not unhealthy as long as this nation has the foresight and good sense to protect those qualities which make rural places attractive to an increasing number of us. We must help insure not only adequate medical care, but also transportation, jobs, education, housing and community facilities to respond to the growth.

In responding to this growth, local, state and federal governments cannot afford to overlook the minorities and poor who have opted for rural life and have been overlooked--and it makes no difference if this was intentional or inadvertent--for so many years. And this includes the special problems in Indian Country.

It is impossible to design an appropriate rural strategy without recognizing the need to revitalize and enhance life in the cities. There must be a national policy which effectively provides Americans the real choice of living in cities, in rural communities or on farms or ranches.

Small and family farmers, who have heard for too many years predictions of extinction, must share the focus of a rural policy with the non-farm population communities.

From California to Massachusetts to the Nation's capital there are efforts to assist farmers and to stop the loss of one million acres of prime farmland to some other development each year. Even in this year of plenty, it is clear we cannot continue to substantially diminish the amount of fertile farmland and still expect our cupboards and iceboxes to be stocked with reasonably priced commodities.

Energy, of course, is another major concern for the farmer and the rural resident as well as for all of us. Rural areas obviously feel the direct impact of the energy war, through new mining developments as well as increased costs for gasoline to commute greater distances and soaring prices for fertilizer.

A rural strategy must recognize, perhaps more so than in the case of our great cities, the diversity of rural areas. There is often not the common thread between Ellicotsville, New York, Luckenbach, Texas, or Delano, California, as there is between New York City, Dallas or Los Angeles.

Earlier I mentioned the physician's assistant who so professionally treated my son. Well, I was a strong advocate of physician assistants and nurse practitioners long before that experience. They make particularly good sense in rural areas where there are fewer doctors and the 24-hour demand on their time is much greater than in urban centers. We know, for example, that doctors practicing in rural areas, as a rule, make less money, work longer hours and have less time off than do their urban colleagues.

The Rural Health Clinic Services Act is of historic consequence to rural America as well as to the medically underserved in urban settings.

As you know, the Rural Health Clinic Services Act changes the Medicare and Medicaid reimbursement policies. It provides Medicare and Medicaid reimbursement for rural health clinic services provided by nurse practitioners and physician assistants.

The Act is the result of Senator Dick Clark's Rural Development Subcommittee. Hearings pointed to the urban-rural disparity of Medicare benefits, largely due to the restrictive nature of the program's reimbursement policies.

The problem discovered was that the Medicare program, the Medicaid program in many states, and most private health insurance companies don't allow payment for the basic health services of nurse practitioners and physician assistants unless a supervising physician is present. Ironically, in many areas in this country nurse practitioners and physician assistants are utilized precisely because of the unavailability of physicians. Therefore residents of those areas must bear a double burden--they are deprived of physicians' care and are also forced to pay insurance premiums for health services that are not reimburseable.

As a result of this bill, Medicare and Medicaid participants will have a greater access to health services, and rural health clinics will have a greater opportunity to achieve financial self-sufficiency.

This bill also initiates a demonstration program to reimburse clinics that are located in urban, medically underserved areas that employ physician assistants or nurse practitioners.

As important as this legislation is to medically underserved Americans, there is much left to accomplish. And we cannot do it all in Washington. In fact, I hope the message is reaching you very clearly that we do not intend to try one more time to impose national solutions on the very specific problems of your respective communities.

The Congress and the President have demonstrated concern and commitment to rural health needs. I am confident that the Department of Health, Education and Welfare is now doing a better job of addressing your concerns. And in the Department of Agriculture, where the dual missions are farm and commodity programs and rural development, we hope we are beginning to do our share.

In addition to the obvious functions, such as financing health care facilities through various Farmers Home Administration programs, we have much broader responsibility. Section 603 of the Rural Development Act of 1972 directs the Secretary of Agriculture to coordinate the activities of other federal agencies which have an impact on rural life. This means HEW, Department of Transportation, Labor, any federal department. For example, the Rural Health Clinic Services Act leaves it up to the Secretary of HEW to define rural. The definition of what is rural is a major question and we hope to participate as Secretary Califano works on the new HEW definition.

I can tell you that Secretary Bob Bergland is taking his coordination responsibility seriously, and we would like to have the opportunity to try to assist you in rural health care matters when you believe our involvement is appropriate.

There is much that can be accomplished beyond the shores of the Potomac. Here on the shores of the Rio Grande, as I am sure you will learn, New Mexico has an impressive record in rural health care. But, like most other things, we started from a very low base.

There is an organization called Presbyterian Medical Services which helps deliver health services to rural residents in northern New Mexico and southern Colorado. I had the pleasure of serving as the chairman of the board. Also, the Presbyterian Hospital Center, the host for this conference, asked me to serve on its board. The University of New Mexico, where I worked before moving to Washington, has done much in providing leadership and innovation in rural health care. And there are organizations like Centro Compesino de Salud, the outgrowth of HELP which is another organization I was associated with, which offer solid community support. So, I have had the opportunity to become somewhat aware of health care issues, at least in this part of the country.

In the past 10 months I have traveled to perhaps half of our great states and the local problems are not that different from what I have experienced in the southwest.

In New Mexico, we not only enjoy committed organizations like Presbyterian Medical Services, the Presbyterian Hospital Center, the University of New Mexico School of Medicine, but also many other individuals and groups. For example, here in Bernalillo County there is a State Representative Fred Mondragon, whom you have probably all met by now, and County Commissioner Robert Hawk who have devoted years to this State's health care needs.

To me, it seems critical for all those concerned with rural health care--elected officials, community groups and private organizations like the Presbyterian Hospital Center--to individually and collectively assume the initiative to see that their efforts are in unison as much of the time as possible. The issues are too large and complicated for us to be able to afford less than a unified, comprehensive approach.

We cannot ignore any of the resources--large or small, public or private--available to respond to rural needs. It seems to me that for our efforts to be successful we must begin at the local level and allow each subsequent jurisdiction to respond and contribute in the best way possible until only those issues which cannot be addressed appropriately at some local level reach Washington.

I would like to spend our remaining time for your questions and comments. Thank you for inviting me.